PLEASE DO NOT STAPLE IN THIS AREA						°FQHC/RHC °Core vis °Immuniza	sit					
PICA						HEALTH IN	ISURANCE C	LAII	M FC	RM		PIC
1. MEDICARE M		HAMPUS ponsor's l		CHAMPVA (VA File #	GROUP HEALTH PLAN (SSN or ID)	FECA OTHE BLK LUNG (SSN) (ID)	900000000F		R		(FOR	PROGRAM IN I
2. PATIENT'S NAME (L				. '	3. PATIENT'S BIRTH DAT	É SEX	4. INSURED'S NAME		lame, Fir	rst Name	e, Middle	e Initial)
Menace, Den						M X F						
5. PATIENT'S ADDRES 16 Pester L					6. PATIENT RELATIONSH Self Spouse	IIP TO INSURED Child Other	7. INSURED'S ADDR	RESS (No	o., Stree	t)		
CITY				STATE	8. PATIENT STATUS	Cring Other	CITY					STAT
Raleigh				NC	Single Marrie	d Other						
ZIP CODE	١,		Jde Area Co		Employed Full-Tin	ne Part-Time	ZIP CODE		TE	LEPHON	VE (INC	LUDE AREA CO
9. OTHER INSURED'S I			5–1212 . Middle Ini		Studen  10. IS PATIENT'S CONDI	Student	11. INSURED'S POLI	CY GBC	OUP OR	FECA N	) IUMREE	
				"/	2010			J. U. 1C		. LOAN		•
a. OTHER INSURED'S F	POLICY OR GROUP	NUMBER	3		a. EMPLOYMENT? (CURF		a. INSURED'S DATE	OF BIRT	Н			SEX
b. OTHER INSURED'S I	DATE OF BIRTH	SEX	·		YES b. AUTO ACCIDENT?	NO PLACE (State)				NAME	1	F
MM DD YY	M	SE)	x F <sup>in</sup>		YES	NO NO	U. EMPLOYER'S NAM	ac oh S	whool.	NAME		
c. EMPLOYER'S NAME	OR SCHOOL NAME				c. OTHER ACCIDENT?		c. INSURANCE PLAN	NAME	OR PRO	GRAM	NAME	
d. INSURANCE PLAN N	AME OR PROCESS	NA NA			YES	NO NO	14 10 TUEST		<b>T</b>			
u. INOUTIANUE PLAN N	AME OH PHOGHAN	NAME			10d. RESERVED FOR LO	AL USE	d. IS THERE ANOTHE	NO NO				omplete 4 *
	BEAD BACK OF E	ORM BE	FORE CO	MPLETING A	& SIGNING THIS FORM.	- Information	13. INSURED'S OR A	UTHOR	ZED PE			omplete item 9
40 DATIFATIO OD 41 IT	HEAD DAGK OF I											
12. PATIENT'S OR AUT to process this claim.	HORIZED PERSON	S SIGNAT	rnment ben	ithorize the re nefits either to	elease of any medical or othe o myself or to the party who	accepts assignment	services described	below.	is to the	undersig		ysician or suppli
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to process this claim. below.  SIGNED  14. DATE OF CURRENT MM DD YY  17. NAME OF REFERRIU  19. RESERVED FOR LO  21. DIAGNOSIS OR NAT  1. L 382 9  24. A DATE(S) OF STORM DD YY  10 20 02  10 20 02  10 20 02  10 20 02  10 20 02	ILLNESS (First INJURY (Accident Precious Accident Precious Acciden	at ornections of the service of the	n) OR OUNCE  Y. (RELATI Type PF Service C Service C 26 PAT 32 NAM REN	15. IF GI 17a. L. 15. IF GI 17	DATE  PATIENT HAS HAD SAM VE FIRST DATE MM  ID. NUMBER OF REFERRI  2.3 OR 4 TO ITEM 24E BY  L	COR SIMILAR ILLNESS. DD	Services described	NO DATE:  OR DAYS:  OR DAYS:  OR UNITS  1  1  1  1  1  1  1  1  1  1  1  1  1	N ORIGO	TO SCHA	D D D D D D D D D D D D D D D D D D D	NT OCCUPATION DO W  NT SERVICES  K  RESERVED L LOCAL US  30. BALANCE   \$ 65  BESS, ZIP CODILTH
to process this claim. below.  SIGNED  14. DATE OF CURRENT MM DD YY  17. NAME OF REFERRIU  19. RESERVED FOR LO  21. DIAGNOSIS OR NAT  1. L 382 9  24. A DATE(S) OF S FROM DD YY  10 20 02  10 20 02  10 20 02  10 20 02  25. FEDERAL TAX LD. NI.  NICLUDING DEGREE (I certify that the staten apply to this bill and and area.)	ILLINESS (First INJURY (Accident Injury) (Accide	at sympton to gove the sympton to sympton to sympton to sympton to sent) OR INJUR'S B Place of Services 11 11 11 11 11 11 11 11 11 11 11 11 11	n) OR OUNCE  Y. (RELATI Type PF Service C Service C 26 PAT 32 NAM REN	15. IF GI 17a. L. 15. IF GI 17	DATE  PATIENT HAS HAD SAM VE FIRST DATE MM  ID. NUMBER OF REFERRI  2.3 OR 4 TO ITEM 24E BY  L	COR SIMILAR ILLNESS. DD	Services described   SIGNED   16. DATES PATIENT   FROM   MM   DI   PROM   PROM   DI   PROM   DI   PROM	NO DATE:  NO DAT	N ORIGINAL MANUAL MERSON MANUAL MERSON MANUAL MERSON MANUAL MERSON MERSO	TO SCHA	D D D D D D D D D D D D D D D D D D D	NT OCCUPATIC DO YY  NT SERVICES K RESERVED L LOCAL US  30. BALANCE   \$ 65
to process this claim. below.  SIGNED  14. DATE OF CURRENT MM DD Y 17.  17. NAME OF REFERRIU  19. RESERVED FOR LO  21. DIAGNOSIS OR NAT  1. L 382 9  2. L A DATE(S) OF 5 FROM DD YY  10 20 02  10 20 02  10 20 02  10 20 02  10 20 02  10 20 02  10 30 02  10 10 20 02  10 10 20 02  10 10 20 02  10 10 20 02  10 10 20 02  10 10 20 02  10 10 20 02  10 10 10 10 10 10 10 10 10 10 10 10 10 1	ILLNESS (First INJURY (Accident Precious Accident Precious Acciden	t sympton to gove the sympton to gove the sympton to sy	nn) OR  C Pyre Relati  Type Po	15. IF GI 17a. L. 15. IF GI 17	DATE  PATIENT HAS HAD SAM VE FIRST DATE MM  ID. NUMBER OF REFERRI  2.3 OR 4 TO ITEM 24E BY  L	ES DIAGNOSIS CODE  ESS DIAGNOSIS CODE  EFT ASSIGNMENT?  JOYLE PT ASSIGNMENT.  JOYLE PT A	services described  SIGNED  16. DATES PATIENT I FROM MM DO 18. HOSPITALIZATION FROM MM DO 20. OUTSIDE LAB?  22. MEDICAID RESUB CODE  23. PRIOR AUTHORIZ  F  \$ CHARGES  65 00  0 00  0 00  28. TOTAL CHARGE  \$ 65 00  39. PHYSICIAN'S, SUP 8, PHONE # C. S. 12  8900000	NO DAYES  NO DAYES  OA DAYES  OA UNITS  1  1  1  1  1  1  1  1  1  1  1  1  1	N ORICE NUMBER HEPSDT Family Plan  9 9 AMOU	PRK IN C TO TO TO TO S CHA	CURREN MM CURREN MM CURREN MM COB STATE OF THE STATE OF T	NT OCCUPATION TO Y  NT SERVICES  K  RESERVED I LOCAL US  30. BALANCE   \$ 65  NESS, ZIP CODI